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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **NECY T. REYES;** **aka NECY REYES TALANAY and** **NECY REYES BALTAZAR** **7815 Kingbee Street** **Downey, CA 90242** **Registered Nurse License No. 396691** Respondent.	Case No. 2010- 641 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 31, 1986, the Board of Registered Nursing issued Registered Nurse License Number 396691 to Necy T. Reyes (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1442, states:

As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

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8. California Code of Regulations, title 16, section 1443, states:

As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

10. At all times herein mentioned, Respondent was assigned to work as a registered nurse in the Pediatric Intensive Care Unit (PICU) at Kaiser Sunset Hospital.

11. On or about February 5, 2007, patient M.A., then a 5 year-old male, was transferred to Kaiser Sunset Hospital from Kaiser Fontana with pneumonia and was admitted to the PICU. In the ensuing days, patient M.A. was diagnosed with necrotizing pneumonia,[1] pneumothorax,[2] and deep vein thrombosis (DVT) in the right femoral line. He had to undergo multiple radiological and laboratory tests, and the placement of chest tube, intubation, and a subclavian line.[3] In addition, patient M.A. was placed on, and his respiration maintained by, a ventilator. Patient M.A.'s condition continued to deteriorate and remained unstable.

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[1] Necrotizing pneumonia is one of the severe forms or complications of pneumonia that is of the community acquired kind. This condition is characterized or marked by cavitations and liquefaction of the lung tissue.

[2] Pneumothorax is a medical condition and potential emergency wherein air or gas is present in the pleural cavity (chest). A pneumothorax can occur spontaneously. It can also occur as the result of disease or injury to the lung or due to a puncture to the chest wall. A pneumothorax can result in a collapsed lung.

[3] Placement of a large-bore venous catheter into the subclavian vein in an emergent situation, to deliver a high flow of fluid or blood products.

12. On or about February 12, 2007, chest x-rays confirmed bilateral pulmonary consolidations consistent with pneumonia and interval increase in right basilar pneumothorax.

13. On or about February 13, 2007, an order was given for a stat chest CT scan. At approximately 23:00 hours, respondent assisted the respiratory care therapist in transporting patient M.A. from PICU to the CT scan department. The policies and procedures in the PICU require that patients be monitored continuously throughout the hospital grounds. In addition, portable monitoring, equivalent staffing, and the ability for emergency resuscitation should be provided for each PICU patient when transported outside the PICU for any reason.

14. Patient M.A. was transported to the CT scan department by Respondent and by the respiratory care therapist. The respiratory care therapist manually ventilated patient M.A. during the transport, however, the patient was not connected to a cardiac monitor because the Respondent forgot to hook the patient up to a portable monitor, or take one with her to the scan room. When the patient arrived in the CT scan department, he was connected to a ventilator with the same ventilator settings as he was on in PICU. However, patient M.A. continued to be without connection to a cardiac monitor while in the CT scan department and during the CT scan procedure. Respondent made no effort to retrieve the forgotten cardiac monitor, nor did she call anyone and ask for one to be delivered.

15. As soon as patient M.A. was ready for the CT scan, Respondent and other personnel retreated into the viewing room. Respondent failed to remain at bedside with the patient for continued monitoring. Respondent left the area and her whereabouts were unknown. The respiratory care therapist fell asleep (or sat with his eyes closed) in the viewing room during the scan.

16. At the conclusion of the approximately fifteen minute scan, patient M.A. was observed to have turned blue in color by his mother, herself a licensed nurse. She immediately called for help. Patient M.A. had no heart rate, and a Code Blue was immediately initiated.

17. Resuscitation efforts were successful, and after several minutes the staff members were able to stabilize the patient. He was eventually transferred back to PICU. Patient M.A. suffered temporary blindness and brain injury but recovered fully without residual injury.

18. Respondent repeatedly failed to consistently, accurately, and legibly chart her continuous monitoring and observation of the patient in PICU, during transport, and while he was in the CT scan department, including failing to chart details of the Code Blue in the patient's records. Respondent was inconsistent with assessments and vital signs throughout the day.

19. Respondent is subject to disciplinary action pursuant to Code section 2761(a)(1) on the grounds of unprofessional conduct, in that on the date indicated above, Respondent was guilty of gross negligence in her care of patient M.A, a critically ill patient, within the meaning of Regulation 1442, as follows:

(a) Respondent transferred or allowed her patient, a critically pediatric patient, to be transported from the PICU to the CT scan department without a monitor;

(b) Respondent failed to return for the forgotten monitor or contact another staff person to deliver one to the CT scan department, knowingly leaving patient M.A., an unstable and critical patient, without proper monitoring; and

(c) Respondent failed to monitor, assess, and chart the patient appropriately.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

20. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 10-19, above.

21. Respondent is subject to disciplinary action pursuant to Code section 2761(a)(1), on the grounds of unprofessional conduct, in that on the date indicated above, Respondent was guilty of incompetence in her care of patient M.A., a critically ill patient, within the meaning of Regulation 1443, as set forth above.

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THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

22. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 10-21, above.

23. Respondent is subject to disciplinary action pursuant to Code section 2761(a), generally, in that Respondent committed acts constituting unprofessional conduct, as set forth above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 396691, issued to Respondent Necy T. Reyes;

2. Ordering Respondent Necy T. Reyes to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 6/16/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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